

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
INPATIENT HOSPITAL SERVICES

Revised: July 1, 1993

1. Inpatient Hospital Services (Continued)

Arkansas State Operated Teaching Hospitals

Arkansas State Operated Teaching Hospitals are classified as a separate class group. The Medicaid definition of a state operated teaching hospital is: A hospital is a state operated teaching hospital if it has in effect an agreement to participate in Medicaid as a hospital, is operated by the State of Arkansas and has current accreditation from the North Central Association of Colleges and Schools.

Arkansas State Operated Teaching Hospitals are reimbursed based on interim per diem rates with year end cost settlement for cost reporting periods ending on or after July 1, 1989. Arkansas Medicaid will use the lesser of cost or charges to establish cost settlements. Except for malpractice insurance, the gross receipts tax and graduate medical education costs, the interim per diem rates and the final cost settlements are calculated in a manner consistent with the method used by the Medicare Program. The definition of allowable costs to be used is as follows:

(a)

The State will use the Medicare allowable costs as stated in the HIM-15 including the cost limitations with the exception of malpractice insurance and the gross receipts tax. For malpractice insurance, a simple calculation will be made outside the cost report and the result added back on to the Medicaid settlement page of the report. The calculation would apply a Medicaid utilization factor based on cost to the portion of total malpractice expense (91.5%) which is reimbursed for Medicare on worksheet D-8 of the cost report. The remaining 8.5% remains on worksheet A of the cost report and flows through to be reimbursed like any other administrative cost. The final result would be to reimburse malpractice for Medicaid as though all malpractice expense remained on worksheet A and simply flowed through the cost report. The gross receipts tax is not an allowable cost.

A	
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The State will use the criteria to determine allowable bad debt referenced in 42 CFR, Section 413.80(e) - criteria for allowable bad debt.

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Arkansas State Operated Teaching Hospitals (Continued)

- (b) Effective with cost reporting periods beginning on or after July 1, 1993, direct medical education costs, including graduate medical education, will be reimbursed using the Medicare rules published in the Federal Register dated September 29, 1989. The only exception to the above Medicare rule will be the inclusion of nursery cost in the calculation of the cost per resident for Medicaid and the State will include nursery days for the allocation of cost to Medicaid. The State will use the Medicare base year for the purpose of calculating the State Operated Teaching Hospitals direct graduate medical education payments.

Effective for cost reporting periods beginning on or after January 1, 1997, Arkansas Medicaid will begin excluding graduate medical education (GME) cost from the interim rate. A separate payment for GME reimbursement will be made quarterly and will be calculated based on the number of paid days for that quarter, arrived from the Medicaid Management Information System, multiplied by the GME reimbursement per day determined by the previous cost reporting period. A reimbursement settlement for GME will be made at the time the cost settlements are processed. The GME reimbursement will be calculated using the Medicare rules published in the Federal Register dated September 29, 1989. The only exception to the above Medicare rules will be the inclusion of nursery cost in the calculation of the cost per resident for Medicaid and the State will include nursery days for the allocation of cost to Medicaid. The State will use the Medicare base year for the purpose of calculating the State Operated Teaching Hospitals direct graduate medical education payments. GME payments will not be subject to the upper limit.

- (c) The base period for the determination of the TEFRA limit will be current year which is the fiscal year ending immediately prior to the first period this change goes into effect. EXAMPLE: The University of Arkansas for Medical Sciences' (UAMS) base period for determination of TEFRA limits will be fiscal year ending June 30, 1989. Only inpatient operating costs are subject to the limit.

Arkansas Medicaid will use the HCFA Market Basket Index or the Congressional Set Inflation Factor for hospitals not subject to the Medicare prospective payment system.

Effective for cost reporting periods ending on or after June 30, 2000, the TEFRA rate of increase limit will no longer be applied to Arkansas State Operated Teaching Hospitals.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
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1. Inpatient Hospital Services (Continued)

Arkansas State Operated Teaching Hospitals (Continued)

- (d) Physicians/Administrative/Teachers will be included in costs as recognized by Medicare HIM-15 reimbursement principles.
- (e) **Arkansas State Operated Teaching Hospital Adjustment: Effective May 9, 2000, Arkansas State Operated Teaching Hospitals shall qualify for an inpatient rate adjustment. The adjustment shall result in total payments to the hospitals that are equal to but not in excess of the individual facility's Medicare-related upper payment limit. The adjustment shall be calculated as follows:**
1. Using the most current audited data, Arkansas shall determine each State Operated Teaching Hospital's base Medicare per discharge rate and base Medicaid per discharge rate.
  2. The base per discharge rates shall be trended forward to the current fiscal year using an annual Consumer Price Index inflation factor.
  3. Once the per discharge rates have been trended forward, the Medicare per discharge rate will be divided by the Medicare case mix index and the Medicaid per discharge rate will be divided by the Medicaid case mix index. The Medicare case mix index reflects the hospital's average diagnosis related group (DRG) weight for Medicare patients. The Medicaid case mix index reflects the hospital's average DRG weight for Medicaid patients using the Medicare DRGs.
  4. The base Medicaid per discharge rate shall be subtracted from the base Medicare per discharge rate.
  5. The difference shall be multiplied by the hospital's Medicaid case mix index.
  6. The adjusted difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent fiscal year. The result shall be the amount of the annual State Operated Teaching Hospital Adjustment.
  7. Payment shall be made on an annual basis before the end of the state fiscal year.

Any costs associated with heart, liver, non-experimental bone marrow, lung and skin transplants will not be reimbursed through a cost settlement. Refer to Attachment 4.19-A, Page 3, for the reimbursement methodology for these procedures.

STATE <u>Arkansas</u>	A
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
INPATIENT HOSPITAL SERVICES

August 1, 1991

1. Inpatient Hospital Services (Continued)

Rehabilitative Hospitals

Effective for dates of service on or after August 1, 1991, rehabilitative hospitals are reimbursed hospital-specific prospective per diem rates, subject to an upper limit, with no cost settlement. Rates will be effective July 1 of each year. The rate year is the State fiscal year, July 1 through June 30.

The prospective per diem rates are established using total reimbursable costs under Medicare principles of reasonable cost reimbursement, except that the gross receipts tax is not an allowable cost. The initial per diem rate is calculated from the hospital's most recent unaudited cost report submitted to Medicare prior to July 1, 1991, trended forward for inflation. Arkansas Medicaid will calculate a new per diem rate annually, based on the provider's most recent unaudited cost report, and adjust the per diem rate for inflation.

The inflation factor used will be the Consumer Price Index for all urban consumers (CPI-U), U.S. city average for all items. We will use the change in the CPI-U during the calendar year before the start of the rate year. For example, we will use the 12-month change in the CPI-U as of December 31, 1991 to set the rates that will be effective July 1, 1992. The inflation adjustment will be made at the beginning of each rate year.

The upper limit is set annually at the 70th percentile of all rehabilitative hospitals' inflation-adjusted Medicaid per diem rate. Arkansas Medicaid will negotiate with the Arkansas Hospital Association annually (State fiscal year July 1 through June 30) regarding adjustment of the 70th percentile upper limit.

4.19-B  
Supersedes, Page 5,  
Item 13.d.1, TN 90-13

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES IN  
INPATIENT HOSPITAL SERVICES

Revised: February 1, 1994

1. Inpatient Hospital Services (Continued)

Inpatient Psychiatric Services for Individuals Under 22 Years of Age

Effective for dates of service on or after August 8, 1991, inpatient psychiatric hospitals are reimbursed for services provided to individuals under 22 years of age using hospital-specific prospective per diem rates plus a \$69.00 component for professional services. The total of the per diem rate plus the professional component is subject to an upper limit with no cost settlement. Rates will be effective July 1 of each year. The rate year is the State fiscal year, July 1 through June 30.

The prospective per diem rates are established using total reimbursable costs under Medicare principles of reasonable cost reimbursement except that the gross receipts tax is not an allowable cost. The initial per diem rate is calculated from the hospital's most recent unaudited cost report submitted to Medicare prior to July 1, 1991, trended forward for inflation. Arkansas Medicaid will calculate a new per diem rate annually, based on the provider's most recent unaudited cost report and adjust the per diem rate for inflation.

The inflation factor used will be the Consumer Price Index for all urban consumers (CPI-U), U.S. city average for all items. We will use the change in the CPI-U during the calendar year before the start of the rate year. For example, we will use the 12-month change in the CPI-U as of December 31, 1991 to set the rates that will be effective July 1, 1992. The inflation adjustment will be made at the beginning of each rate year.

The \$69.00 professional component is the average of the rates for the individual psychotherapy procedure codes. The amount of the professional component will be adjusted whenever the Arkansas Medicaid physician fee schedule is adjusted.

Effective for claims with dates of service on or after February 1, 1994, the upper limit is set annually at the 60th percentile of all inpatient psychiatric hospitals' inflation-adjusted Medicaid per diem rates. The upper limit will be calculated annually effective February 1st of each year.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
INPATIENT HOSPITAL SERVICES

July 1, 1993

1. Inpatient Hospital Services (Continued)

Inpatient Psychiatric Hospital Services For Individuals Under 22 Years of Age (Continued)

Effective for dates of service on or after July 1, 1993, the State will reimburse the lesser of cost or a maximum of \$316.00 per day for residential treatment units located within inpatient psychiatric hospitals. The State will reimburse the lesser of audited cost or a maximum of \$316.00 per day. Cost is defined as total reimbursable costs under Medicare principles of reasonable cost reimbursement, except the gross receipts tax is not an allowable cost. The initial maximum of \$316.00 represents the average budgeted cost per day of the in-state freestanding residential treatment centers for State Fiscal Year 1994. The State will review the maximum annually (July 1 through June 30). The budgeted data for the upcoming State Fiscal Year submitted by the in-state freestanding residential treatment centers prior to the end of the State Fiscal Year will be used to determine the new maximum for each new State Fiscal Year. The new maximum will be effective for dates of service on or after July 1 of the new State Fiscal Year. For each State Fiscal Year after the initial year, the State will set the maximum per diem at the average budgeted cost per day for in-state freestanding residential treatment centers (RTC's). If the average budgeted cost per day for the in-state freestanding RTC's changes at all, the State will calculate a new cap, and the new cap will be equal to the average of in-state freestanding RTC's.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
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Revised: July 1, 1995

2. Disproportionate Share Payment (Continued)

Rural area hospitals are defined as all hospitals that are not in a Metropolitan Statistical Area (MSA). The following list includes all of the currently identified Arkansas MSA counties and some of the currently identified border state MSA counties. Hospitals located in a MSA are defined as urban area hospitals.

- |                          |                           |
|--------------------------|---------------------------|
| 1. Crawford County, AR   | 9. Sebastian County, AR   |
| 2. Crittenden County, AR | 10. Washington County, AR |
| 3. Faulkner County, AR   | 11. Desota County, MS     |
| 4. Jefferson County, AR  | 12. Sequoyah County, OK   |
| 5. Lonoke County, AR     | 13. Shelby County, TN     |
| 6. Miller County, AR     | 14. Tipton County, TN     |
| 7. Pulaski County, AR    | 15. Bowie County, TX      |
| 8. Saline County, AR     |                           |

Calculation of the Disproportionate Share Payment Adjustments

Rural acute care hospitals qualifying under the Medicaid inpatient utilization rate.

Each rural hospital's disproportionate share payment adjustment will be based on standard deviation increments above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State.

Effective July 1, 1995, each rural hospital's annual disproportionate share payment adjustment is calculated on the following formula, but will not exceed the disproportionate share hospital limit.

A \$1,000 minimum payment amount, plus

A year end cost settlement based on Medicaid paid days for that period using the following percentages:

Standard Deviation  
Above the Mean

At least .5 and less than 1  
At least 1 and less than 2  
At least 2 and less than 3  
At least 3 or greater

Year End Cost  
Settlement

7 percent  
8 percent  
9 percent  
10 percent

STATE <u>Arkansas</u>	A
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
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2. Disproportionate Share Payment (Continued)

Urban acute care hospitals qualifying under the Medicaid inpatient utilization rate.

Each hospital's disproportionate share payment adjustment will be based on the percentage by which its Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State.

Effective July 1, 1995, each hospital's annual disproportionate share payment adjustment is calculated on the following formula, but will not exceed the disproportionate share hospital limit.

A \$1,000 minimum payment amount, plus

10 percent (X) [individual hospital's Medicaid inpatient utilization rate minus one standard deviation above the mean Medicaid inpatient utilization rate] (X) [the hospital's fiscal year Medicaid per diem reimbursement].

The fiscal year Medicaid per diem reimbursement is the allowable costs from each provider's cost report and not the interim per diem payments made during the year.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
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Revised: July 1, 1995

2. Disproportionate Share Payment (Continued)

Acute care hospitals qualifying under the low-income utilization rate.

Each hospital's disproportionate share payment adjustment will be based on the hospital's low-income utilization rate.

Effective July 1, 1995, each hospital's annual disproportionate share payment is calculated on the following formula, but will not exceed the disproportionate share hospital limit.

A \$1,000 minimum payment amount, plus

4 percent (X) [individual hospital's low-income utilization rate minus 25 percent] (X) [the hospital's fiscal year Medicaid per diem reimbursement].

The fiscal year Medicaid per diem reimbursement is the allowable cost from each provider's cost report and not the interim per diem payments made during the year.

If an acute care hospital qualifies as a disproportionate share hospital under both the Medicaid inpatient utilization rate and low-income utilization rate, Arkansas Medicaid will only make a disproportionate share payment under one method. For those hospitals that qualify for disproportionate share payment under the Medicaid inpatient utilization rate and also under the low-income utilization rate, Arkansas Medicaid will use the method which gives the hospital the larger payment.

STATE <u>Arkansas</u>	A
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Revised: July 1, 1995

2. Disproportionate Share Payment (Continued)

Inpatient psychiatric and rehabilitative hospitals.

Inpatient psychiatric and rehabilitative hospitals meeting disproportionate share payment eligibility criteria will receive a disproportionate share payment year end cost settlement equal to the rate which is paid to the urban acute care hospitals.

For inpatient psychiatric and rehabilitative hospitals (both urban and rural) that qualify under the Medicaid inpatient utilization rate, the disproportionate share hospital payment adjustment will be determined using the methodology for urban acute care hospitals qualifying under the Medicaid inpatient utilization rate. It is important to note that the numerator of the MUR formula does not include days attributable to Medicaid patients between 21 and 65 years of age in Institutions for Mental Disease (IMDs). These patients are not eligible for Medical Assistance under the State Plan for the days in which they are inpatients of IMD's and may not be counted as Medicaid days in computing the Medicaid utilization rate. For inpatient psychiatric and rehabilitative hospitals (both urban and rural) that qualify under the low-income utilization rate, the disproportionate share hospital payment adjustment will be determined using the methodology for acute care hospitals qualifying under the low-income utilization rate.

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